



**CONFIDENTIAL**  
**Oswego County Opportunities, Inc.**  
 239 Oneida Street – Fulton, NY 13069  
 Phone: (315)-598-4717

# INCIDENT REPORT

Serious Incident     Critical Incident

Division:

**Section A: REQUIRED** (for all incidents)

Date of Incident:				Address where incident occurred: (Work site, intersection, client's home, etc.)		
Time of Incident: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.				County where incident occurred:		Oswego
				Was the incident on OCO property? <input type="checkbox"/> Yes <input type="checkbox"/> No		
E = Employee C = Consumer V = Volunteer O = Other		<i>Using the key to the left, identify the parties below, by checking the appropriate column.</i>		PARTIES INVOLVED		CONTACT INFORMATION
<b>E</b>	<b>C</b>	<b>V</b>	<b>O</b>	List all persons involved below		Phone Number
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>WITNESSES: Were there any witnesses?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, complete the following:		
1. Name:		Address:		Phone:		
2. Name:		Address:		Phone:		
3. Name:		Address:		Phone:		

**Section B: EMPLOYEE INCIDENT**

Full Time     Part Time     Sub

Employee's Name:		Program where Employed:	
Home Address :		Occupation/Title:	
City:		State: NY	ZIP:
Normal Schedule: <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat		Date Supervisor was notified:	
<b>What was the Employee doing when the incident occurred?</b>			
<b>Describe the Incident:</b>			
<b>Nature of Injury and Body Parts Affected:</b>			
<b>Was medical attention necessary?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, time seen:</b>
			<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
<b>Physician/Hospital Name:</b>		Was any time lost from work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Physician/Hospital Address:</b>		Last Day Worked:	
Is there suspected exposure to Bloodborne Pathogens? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, was a Blood and Bodily Fluids report completed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>EMPLOYEE INJURY?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>If Yes, Fax or send the front of this form to HR at 598-4006 immediately</b>			<b>FAX sent?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

**Section C: NON-EMPLOYEE INCIDENT**

Program:

Describe the Incident/Injury/Exposure:

Was medical attention necessary?  Yes  No (If YES, fill in the information below)

Physician/Hospital Name:	Is there suspected exposure to bloodborne pathogens? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician/Hospital Address:	Have appropriate program-specific forms been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No

If available, attach physician's statement

**Section D: ACTIONS TAKEN AS A RESULT OF THE INCIDENT**

1. Was First Aid administered? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Describe the First Aid given:
<b>If this incident occurred in Head Start, Daycare, or UPK, answer questions 3 – 5. All other programs skip to question 6.</b>	
3. How were parent(s) notified?	4. Who notified the parent(s)?
5. Appearance of affected area when child left:	
6. Division:	7. Program:
8. Person completing this form:	9. Job Title:
Signature of person completing this form:	Date:

**Section E: Supervisory Review & Proposed Follow-up Actions to Prevent Recurrence**

Supervisor Review	Program Coordinator Review	Division Director Review
Initials: _____ Date: _____	Initials: _____ Date: _____	Initials: _____ Date: _____
Recommended Actions	Health Coordinator Review	Recommended Actions
	Initials: _____ Date: _____	
	Recommended Actions	
Target Date: _____	Target Date: _____	Target Date: _____

**Routing and Copying**

Divisions – copy & send if:

- Safety Related?  Yes  No (If yes, copy to Safety Committee)
- Accounting/Facility Related?  Yes  No (If yes, copy to Director of Finance)
- Employee Injury?  Yes  No (If yes, copy to Human Resources)
- Computer Related?  Yes  No (If yes, copy to Information Technology)

ORIGINAL – Send to Executive Director